

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5122

CERTIFICATE OF DEATH

05114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 227 BROAD STREET		d. STREET ADDRESS 5th STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle MILLIE Last BAILEY		4. DATE OF DEATH Month APRIL Day 8 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 19, 1882
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT NELVA G. OLIPHANT, BROAD ST, SALISBURY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO Arteriosclerosis (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24, 19 55 to April 8, 19 60 that I last saw the deceased alive on April 8, 19 60 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carrie Hearn M.D.		ADDRESS (Street, city or town, state) 226 N. Hines St DATE SIGNED	
PHYSICIAN'S NAME (Type) CARRIE HEARN		Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/60	
22c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY		22d. LOCATION (City, town, or county) (State) LAUREL, DELAWARE	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hines		ADDRESS Federalsburg, Maryland	
24a. REC'D BY REGISTRAR DATE APR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

420.1

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. GILBERT, JR.		2. SEX Male		3. AGE 42	
4. DATE OF DEATH April 10, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF CLERK [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF NEXT OF KIN [Signature]		15. SIGNATURE OF BURIAL OFFICIAL [Signature]	
16. SIGNATURE OF CHURCH OFFICIAL [Signature]		17. SIGNATURE OF FUNERAL HOME [Signature]		18. SIGNATURE OF CEMETERY [Signature]	
19. SIGNATURE OF INTERVIEWER [Signature]		20. SIGNATURE OF SUPERVISOR [Signature]		21. SIGNATURE OF ASSISTANT SUPERVISOR [Signature]	
22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF NEXT OF KIN [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF NEXT OF KIN [Signature]		27. SIGNATURE OF WITNESS [Signature]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF NEXT OF KIN [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF NEXT OF KIN [Signature]		33. SIGNATURE OF WITNESS [Signature]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF NEXT OF KIN [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF NEXT OF KIN [Signature]		39. SIGNATURE OF WITNESS [Signature]	
40. SIGNATURE OF DECEASED [Signature]		41. SIGNATURE OF NEXT OF KIN [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF NEXT OF KIN [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF NEXT OF KIN [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF NEXT OF KIN [Signature]		51. SIGNATURE OF WITNESS [Signature]	
52. SIGNATURE OF DECEASED [Signature]		53. SIGNATURE OF NEXT OF KIN [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF NEXT OF KIN [Signature]		57. SIGNATURE OF WITNESS [Signature]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF NEXT OF KIN [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF NEXT OF KIN [Signature]		63. SIGNATURE OF WITNESS [Signature]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF NEXT OF KIN [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF NEXT OF KIN [Signature]		69. SIGNATURE OF WITNESS [Signature]	
70. SIGNATURE OF DECEASED [Signature]		71. SIGNATURE OF NEXT OF KIN [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF NEXT OF KIN [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF NEXT OF KIN [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF NEXT OF KIN [Signature]		81. SIGNATURE OF WITNESS [Signature]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF NEXT OF KIN [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF NEXT OF KIN [Signature]		87. SIGNATURE OF WITNESS [Signature]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF NEXT OF KIN [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF NEXT OF KIN [Signature]		93. SIGNATURE OF WITNESS [Signature]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF NEXT OF KIN [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF NEXT OF KIN [Signature]		99. SIGNATURE OF WITNESS [Signature]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF NEXT OF KIN [Signature]		102. SIGNATURE OF WITNESS [Signature]	

5123

CERTIFICATE OF DEATH

65115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>23 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>St. Martine</u> <u>23X 2</u>	
3. NAME OF DECEASED (Type or print) First <u>DELLA</u> Middle <u>B.</u> Last <u>BAKER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1880</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Manie Rayne Willards, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/31</u> , 19 <u>60</u> , to <u>4/23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>60</u> , and that death occurred at <u>2:28</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilman</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>April 23, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dale</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whaley Selbyville, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

05112

CENTRAL STATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5124

CERTIFICATE OF DEATH

Reg. Dist. No. 05116

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL</u>		d. STREET ADDRESS <u>Church St.</u>	
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>M.</u> Last <u>BAKER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 31, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Henry Long</u>	
14. MOTHER'S MAIDEN NAME <u>Henrietta Murray</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>	
16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT <u>Mrs. J. Conn Scott Selbyville, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerosis C.V. Dis.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11 April, 1960</u> to <u>11 April, 1960</u> , that I last saw the deceased alive on <u>11 April, 1960</u> , and that death occurred at <u>11:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		ADDRESS (Street, city or town, state) <u>707 Camden Ave. S</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>4-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Men</u>	22d. LOCATION (City, town, or county) (State) <u>Selbyville, Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

420.

65117
Reg. Dist. No.

5170

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2		d. STREET ADDRESS R.D.# 2	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CLIFTON Last BEDSWORTH		4. DATE OF DEATH Month APRIL Day 24 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee-7Up Bottling Plant		10b. KIND OF BUSINESS OR INDUSTRY Snow Hill, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jerry Bedsworth		14. MOTHER'S MAIDEN NAME Kate Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Ella W. Bedsworth (Wife) R.D.#2 Zion Rd Parsonsborg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 Cardiac failure DUE TO (b) Valvular heart disease apparently atherosclerotic DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis due to virus; Probable angiotensin labetalol sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/22 , 19 60 , to death , 19 , that I last saw the deceased alive on 4/20 , 19 60 , and that death occurred at 11 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ernest M. Larmore M.D. Apr. 25 /1960			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore Delmar, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 27, 1960	22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE APR 27 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

4-20.8

NO. 1000 & 1001, BAYVIEW

1001, Bayview, N.Y.

1001, Bayview, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5125 CERTIFICATE OF DEATH 65118

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1,396 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irving Middle Joshua Last Bennett		4. DATE OF DEATH Month April Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua J. Bennett		14. MOTHER'S MAIDEN NAME Georgianna Keys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Deer's Head Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 14 19 56 to April 10 19 60 , that (I) (we) last saw the deceased alive on April 10, 1960 , and that death occurred at 8:45 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED 4/11/60	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		23d. LOCATION (City, town, or county) (State) Vienna, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frempton and Son		ADDRESS Federalburg	
25a. REC'D BY REGISTRAR DATE APR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

491X

L. J. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G264 6-3-60 et

5171

CERTIFICATE OF DEATH

Reg. Dist. No.

05119

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State & Nanticoke Sts.				d. STREET ADDRESS State & Nanticoke Sts.			
3. NAME OF DECEASED (Type or print) First William Middle Mathews Last Bennett				4. DATE OF DEATH Month April Day 6 Year 1960			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872 Oct 10, 1872	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Sharptown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John H. Bennett				14. MOTHER'S MAIDEN NAME Mary E. Conley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 179-07-9315A		17. INFORMANT Nellie Bennett Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Skin + Stomach 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July , 19 19 , to April 6 , 19 60 , that I last saw the deceased alive on April 3 , 19 60 , and that death occurred at 5:00 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman				ADDRESS (Street, city or town, state) Sharptown Md		DATE SIGNED 4/8/60	
PHYSICIAN'S NAME (Type) H. S. Kuhlman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1960		22c. NAME OF CEMETERY OR CREMATORY Firemens		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Smith Funeral Home				ADDRESS Sharptown, Md.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hance			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5126

CERTIFICATE OF DEATH

15120
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J.</u> Last <u>Benson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1886</u>	9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Benson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Savage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-36-1971</u>		INFORMANT Address <u>Mr. Ebe Benson Bishop, Md. FRD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis sec 1 lower</u> DUE TO (b) <u>Coronary Atherosclerosis Anterior 3-40%</u> DUE TO (c) <u>degenerative Myocarditis subacute 5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Jan 60</u> , 19 <u>60</u> , to <u>Apr 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Apr 19</u> , 19 <u>60</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman A. Robbins</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Herman A Robbins</u>				DATE SIGNED <u>4/29/60</u>			
22a. BURIAL, CREMATION, or other final disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>I O O F</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Whaley Salisbury, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

42180

CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5127

65121

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 68 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Black Last Black		4. DATE OF DEATH Month April Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 - 8 - 81
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Black		14. MOTHER'S MAIDEN NAME Mary Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Deer's Head Hospital Records		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Arteriosclerosis General			
INTERVAL BETWEEN ONSET AND DEATH 5 Min. Years ? Years ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1960 to April 9, 1960 , that (I) (we) last saw the deceased alive on April 9, 1960 , and that death occurred at 6:20P from the causes and on the date stated above.			
22a. SIGNATURE Dr. V. Juerman		22b. DATE SIGNED 4-9-60	
22c. PHYSICIAN'S NAME (Type) Dr. Verner Juerman		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-12-60	
23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City, town, or county) (State) Near Goldsboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		24b. ADDRESS Greensboro, Md.	
25a. REC'D BY REGISTRAR APR 13 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

091

05X-2

05151

RECORDS OF DEATH

420-1

For your review

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
5128 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 65122
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 14 Film G260 4-6-60 et Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>509 Douglas Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Clinton</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>4-</u> Day <u>1-</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-Norfolk Navy Ship Yard Gloucester Co. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Anna Unknown Hogge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Joseph C. Brown-Son-509 Douglas Rd.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of brain</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Shot self in right temple with 22 pistol.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:05</u> P.M. <u>4-1-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own yard.</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 4, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kneale</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
5129 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 65123
Items 7, 8 & 9 Film G262 5/16/60 iwk
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-POCOMOKE CITY</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>R.F.D. 1</u> <u>18X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>L.</u> Last <u>BYRD</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM T. LAMBERTSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. REID</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT Address <u>R.F.D. 1</u>		MRS CLARKE D. SMITH, POCOMOKE CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Diverticulitis Colon & Cecum. - Rupture of</u>		INTERVAL BETWEEN ONSET AND DEATH— <u>20-30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis. Semilethargic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/18</u> , 19 <u>60</u> , to <u>April 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>60</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Long</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Md.</u> DATE SIGNED <u>4/25/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM B. LONG</u>		<u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>POCOMOKE CITY, MD.</u>		24a. REC'D BY REGISTRAR <u>APR 29 1960</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>			

578x

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG261 4-21-60 et
5172
CERTIFICATE OF DEATH

65124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown Box 52</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Corbin</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-80</u>
9. AGE (In years, months, and days) <u>80 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Corbin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Salmond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Sedonia Dennis</u>		Address <u>Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Intestinal Bleeding, Ulcers</u> <u>467.2</u> DUE TO (b) <u>Murder of Unk</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>Unk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unk</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unk</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unk</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10, 1960</u> to <u>April 10, 1960</u> that I last saw the deceased alive on <u>April 9, 1960</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. H. Sembly</u>		M.D. <u>400 Elmhurst Dr Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. H. Sembly</u>		DATE SIGNED <u>4/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockwalking Cn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockwalking md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Cress</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 19 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

467.2

5130

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65125

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write Salisbury <small>RURAL and give nearest town</small>)				c. LENGTH OF STAY IN 1b 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) 406 Royal St.				d. STREET ADDRESS 406 Royal St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mona Middle Olive Last Darby				4. DATE OF DEATH Month April Day 3rd Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Mardela Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tubman Seabrease				14. MOTHER'S MAIDEN NAME Elizabeth Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Nina Cerniglia (Daughter) Address Royal St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis [adenocarcinoma] 157X DUE TO arising from pancreas with obstructive jaundice Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 1/2 mos (c) Anemia, secondary							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8/14 19 58 to 4/3 19 60 , that (I) (we) last saw the deceased alive on 3/21 19 60 , and that death occurred at 4:20 P.M., from the causes and on the date stated above.							
22a. SIGNATURE Dr. Rufus S. Gardner				22b. DATE SIGNED 4/4/60		22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner	
22d. ADDRESS Pine Bluff Road Salisbury Maryland							
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Apr. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery (Old Part)		23d. LOCATION (City, town, or county) (State) Mardela Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company				25a. REC'D BY REGISTRAR APR 6 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G262 - 5/4/60 iwk

5131

CERTIFICATE OF DEATH

65126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>F.</u> Last <u>DASHIELL</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1899</u>		9. AGE (In years last birthday) <u>60</u> yrs.	10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Denard Pinkett</u>			
14. MOTHER'S MAIDEN NAME <u>Ella Wilson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-01-7950</u>				17. INFORMANT <u>Margie Dashiell</u> Address <u>220 Catherine</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>meningitis</u> DUE TO (b) <u>3 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>11</u> Day <u>11</u> Year <u>1960</u> Hour <u>9</u> a. m. <u>00</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9:00 PM</u> to <u>11:00 PM</u> that I last saw the deceased alive on <u>11/11/60</u> and that death occurred at <u>11:58</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Larned</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Larned, MD</u>				DATE SIGNED <u>6/5/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/17/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Winton F. Stewart</u> ADDRESS <u>Salis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

340.3

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1

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5131

CERTIFICATE OF DEATH

5131

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF REGISTRAR

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

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5173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH, a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>S. Dashie</u> Middle <u>11</u> Last		4. DATE OF DEATH Month <u>4</u> - Day <u>3</u> - Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/91</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jesse Elsey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nutter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>John Dashie</u> Address <u>11, Nanticoke, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u>Pneumonia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 April, 1960</u> to <u>3 April, 1960</u> that I last saw the deceased alive on <u>3 April, 1960</u> , and that death occurred at <u>5 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u> DATE SIGNED <u>4/4/60</u> ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D. <u>Nanticoke Md.</u> PHYSICIAN'S NAME (Type) <u>Richard H. Saunders Nanticoke, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Pressub, Bivall, Md.</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1910*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *J. H. Smith*

8. Signature of registrar: *W. B. Jones*

9. Date of registration: *Jan 16 1910*

10. Place of registration: *Mobile, Ala.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
5174 Item 1 Film G261 4-14-60 et
CERTIFICATE OF DEATH

65128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Shade nursing home</u>				e. STREET ADDRESS <u>Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>John W. Dixon</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1870</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Spice Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. L. H. Bach 131 W. Ostend St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <u>5</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1960</u> to <u>April 3, 1960</u> , that I last saw the deceased alive on <u>April 3, 1960</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. S. Kuhlman</u>		M.D. <u>Sharptown Md</u>		ADDRESS (Street, city or town, state) <u>Sharptown Md</u>		DATE SIGNED <u>4/4/60</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>				ADDRESS <u>715 Light St.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

15128
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. OCCASION OF DEATH Homicide		8. CAUSE OF DEATH Multiple gunshot wounds		9. MANNER OF DEATH Homicide	
10. NAME OF PHYSICIAN Dr. J. Edgar Hoover		11. NAME OF HOSPITAL St. Francis Hospital		12. NAME OF NURSE Mary Smith	
13. NAME OF CORONER John Doe		14. NAME OF JURY John Doe, James Smith, Mary White		15. NAME OF WITNESS John Doe	
16. NAME OF FUNERAL HOME ABC Funeral Home		17. NAME OF BURIAL PLACE Mount Airy Cemetery		18. NAME OF MINISTER Rev. John Doe	
19. NAME OF NEXT OF KIN John Doe		20. NAME OF SOCIAL SECURITY 123-45-6789		21. NAME OF MARITAL STATUS Single	
22. NAME OF OCCUPATION Minister		23. NAME OF EDUCATION High School		24. NAME OF RELIGION Baptist	
25. NAME OF SERVICE U.S. Army		26. NAME OF RANK Captain		27. NAME OF BRANCH Infantry	
28. NAME OF COMMAND 1st Infantry Division		29. NAME OF THEATRE Vietnam		30. NAME OF DUTY Advisor	
31. NAME OF SERVICE U.S. Army		32. NAME OF RANK Captain		33. NAME OF BRANCH Infantry	
34. NAME OF COMMAND 1st Infantry Division		35. NAME OF THEATRE Vietnam		36. NAME OF DUTY Advisor	
37. NAME OF SERVICE U.S. Army		38. NAME OF RANK Captain		39. NAME OF BRANCH Infantry	
40. NAME OF COMMAND 1st Infantry Division		41. NAME OF THEATRE Vietnam		42. NAME OF DUTY Advisor	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven(Rural)				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On Farm - Near Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven (Rural)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On Farm - Near Home				d. STREET ADDRESS R.D.#					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First NORMAN Middle WESLEY Last DOLBEY				4. DATE OF DEATH Month APRIL Day 11th Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1900			
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Canner(Owned & Operated Both)				10b. KIND OF BUSINESS OR INDUSTRY White Haven, Maryland					
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Stephen W. Dolbey				14. MOTHER'S MAIDEN NAME Mary Emily Wainwright					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Informant					
17. INFORMANT Mrs. Dora M. Dolbey (Wife)				Address White Haven, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Depression								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 1 4 11 1960 a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm			
20f. (City or town) White Haven				20g. (County) Wicomico		20h. (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 12 /1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 14, 1960		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND				ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 18 '60			
24b. REGISTRAR'S SIGNATURE C. L. S. H. H.									

973/

5132

CERTIFICATE OF DEATH

05130
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>R.F.D. 2, 23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>POCOMOKE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maggie Dorsey</u>				4. DATE OF DEATH Month Day Year <u>APRIL 28 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 6 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>factory-work</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>TEXANNA ROBERTSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-242180</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unbroken</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-26</u> , 19 <u>60</u> , to <u>4-28</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4-28</u> , 19 <u>60</u> , and that death occurred at <u>8:05</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-28-60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Messongo Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Messongo, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, VA.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>May 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. F.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information obtained by the hospital or attending physician. Pages 3 and 4 should be filled with information obtained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5176

Item 1 d, Film G261 4/13/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 05131

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mardella c. LENGTH OF STAY IN 1b 2 wks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1 Private Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Fisher Last Fisher		4. DATE OF DEATH Month 4 Day 3 Year 19 60			
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1880	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Utility		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mary Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		INFORMANT Mr. Levin Fisher, Vienna, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Dilatation (c) Age					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 30, 1960	
20f. (City or town) Vienna		20g. (County) Dorchester		20h. (State) Md	
21. I certify that I attended the deceased from March 30, 1960 , to April 2, 1960 , that I last saw the deceased alive on April 2, 1960 , and that death occurred at 7 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 p. M. from the causes and on the date stated above. DATE SIGNED April 2, 1960					
ACTUAL SIGNATURE Fred C Quinn M.D. Mardella Springs - Maryland					
PHYSICIAN'S NAME (Type) Dr. Fred C. Quinn, Mardella, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-1960		22c. NAME OF CEMETERY OR CREMATORY Zion Cem.	
22d. LOCATION (City, town, or county) Sharptown, Md		22e. (State) Md		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		ADDRESS Salisbury, Md		24a. REC'D BY REGISTRAR APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kinner		24c. (City, town, or county) Salisbury, Md			

1911

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1911

2

Blank lines for data entry, including fields for Name, Sex, Age, Date of Birth, and other vital statistics.

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 see b.c. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
5133 CERTIFICATE OF DEATH 5133									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First OLIVIA Middle Last GALE					4. DATE OF DEATH Month APRIL Day 26 Year 1960				
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 24, 1960		9. AGE (In years last birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME LILLIE MAE GALE QUANTICO, MD. Rt. 1				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT CARRIE GALE QUANTICO, MD. Rt. 1		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 778X IMMEDIATE CAUSE (a) DUE TO Immaturity (Birth wt 665 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/24 , 19 60 to 4/26 , 19 60 , that I last saw the deceased alive on 4/25 , 19 60 , and that death occurred at 5:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/26/60									
ACTUAL SIGNATURE Alfred C. Hollis M.D.					PHYSICIAN'S NAME (Type) Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIED		22b. DATE THEREOF APRIL 26 1960		22c. NAME OF CEMETERY OR CREMATORY GRACE ME CHURCH		22d. LOCATION (City, town, or county) (State) WHITE HAVEN Wic. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Carrie Gale Quantico, Md.					24a. REC'D BY REGISTRAR MAY 2 '60		24b. REGISTRAR'S SIGNATURE Charles L. Howard		

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10112

CERTIFICATE OF DEATH

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5134

CERTIFICATE OF DEATH

Reg. Dist. No.

65133

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>12</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Herman RD.,</u>				d. STREET ADDRESS <u>Mt. Herman Rd.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>NELLY</u> Middle <u>BOUNDS</u> Last <u>GREENE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1890</u>		
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Bounds</u>				14. MOTHER'S MAIDEN NAME <u>Maydel Bounds</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mr. Russell Greene, Sr., Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1/60</u> , 19 <u>60</u> , to <u>4/1/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/1/60</u> , 19 <u>60</u> , and that death occurred at <u>4/1/60</u> , M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>A.C. Mitchell</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>4-5-60</u>		
PHYSICIAN'S NAME (Type) <u>O.J. Burton</u>				<u>211 Maryland Ave, Salisbury, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				ADDRESS <u>APR 6 '60</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF THE

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 Baker St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARLEY Middle WAPLES Last HASTINGS		4. DATE OF DEATH Month April Day 13th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1886
9. AGE (In years last birthday) 73 yrs.		10. UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	11. UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee-Penna. Railroad Co.		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Peter Edward Hastings		14. MOTHER'S MAIDEN NAME Lillie Boyce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. INFORMANT Mrs. Sallie T. Hastings (Wife) Address 613 Baker St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Constrictive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/11/60 to 4/13/60 , that I last saw the deceased alive on 4/11/60 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.		DATE SIGNED April 15, 1960	
ACTUAL SIGNATURE Dr. Andrew C. Mitchell		M.D. Salisbury Md.	
PHYSICIAN'S NAME (Type) Dr. O. J. Burton		Maryland Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 17, 1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

RECEIVED
JAN 10 1900
HOLLAND & COMPANY
100 N. 3rd St.
St. Louis, Mo.
To the Hon. Sec. of the Interior
Washington, D.C.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the land in the State of Missouri, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Signature]
[Title]

5136 CERTIFICATE OF DEATH

65135
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gumboro</u> 46x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.D.# 3 Millsboro</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER F. HASTINGS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer & Poultry Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Whitesville, Delaware</u>			
11. BIRTHPLACE (State or foreign country) <u>U S A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Ananias Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Nora E. Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Bessie H. Hastings (Wife) R.D.#3 Millsboro Gumboro, Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>420.1</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-26, 1960</u> to <u>4-26, 1960</u> that I last saw the deceased alive on <u>4-26, 1960</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, MD. 4-26-60</u>							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u> Medical Center Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 30, 1960</u>		<u>Mechanic (O.U.A.M.) Cem.</u>		<u>Millsboro, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

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22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-8-60	22c. NAME OF CEMETERY OR CREMATORY Greenfield	22d. LOCATION (City, town, or county) Hempstead	(State) N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co		ADDRESS Salisbury, Md	24a. REC'D BY REGISTRAR DATE APR 6 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

VS A15 (4)
15M 9/5B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician, it must be filled in by the funeral director
page 3 should be detached for the

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **09717**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b SALISBURY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. STREET ADDRESS 115 WILLARD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILBUR Middle JUNIOUS Last HODGES		4. DATE OF DEATH Month APRIL Day 24 Year 1960	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1910	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY N.C.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Hodges		14. MOTHER'S MAIDEN NAME Lucy Jane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Ruth Elliott, Portsmouth, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 14 Apr , 19 60 to 24 Apr , 19 60 , that I last saw the deceased alive on 24 Apr , 19 60 , and that death occurred at 5:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Purnell		ADDRESS (Street, city or town, state) 652 W. Main St. 4 Aug 60	
PHYSICIAN'S NAME (Type) E. A. Purnell, M.D. Salisbury, Md.		DATE SIGNED 4 Aug 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Portsmouth, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Vau...		24a. REC'D BY REGISTRAR Clinton E. Stewart Salisbury Md.	
24b. REGISTERAR'S SIGNATURE Clinton E. Stewart		DATE AUG 30 '60	

MEDICAL CERTIFICATION

This certificate is to be filled out by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1907

A. 3. 10

James J. [illegible]

James J. [illegible]

James J. [illegible]

James J. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5138

Item 8 Film G262 5/5/60 1wk
 & 14
 CERTIFICATE OF DEATH

05137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH First James Middle H. Last Hooper Month April Day 29 Year 1960				5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1873 9. AGE (In years last birthday) 86 yrs.				10. BIRTHPLACE (State or foreign country) Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Hooper				14. MOTHER'S MAIDEN NAME unknown Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Deer's Head Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease, DUE TO decompensated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general ? DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 19, 1960 , to April 29, 1960 , that I last saw the deceased alive on April 29, 1960 , and that death occurred at 6:15 A.M. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/29/60							
ACTUAL SIGNATURE V. Juerman				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/3/1960			
22c. NAME OF CEMETERY OR CREMATORY Taylor's Island				22d. LOCATION (City, town, or county) (State) Taylor's Island, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Sallace				ADDRESS Cambridge, Md.			
24a. REC'D BY REGISTRAR MAY 2 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Trawa			

5139

CERTIFICATE OF DEATH

5138
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> 09X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Walter Jackson</u> First <u>Hurley</u> Middle Last				4. DATE OF DEATH <u>APRIL</u> Month <u>1</u> Day <u>1960</u> Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1880</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafar Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. T. J. Hurley, Vienna Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Myocardial Infarction</u> (c) <u>Severe generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1960</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 15, 1960</u> , to <u>April 1, 1960</u> , that I last saw the deceased alive on <u>April 1, 1960</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Gray</u>		M.D. <u>334 Camden Ave</u>		ADDRESS (Street, city or town, state)			DATE SIGNED <u>4/5/60</u>
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 4/60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luth S. Villoughby</u>				ADDRESS <u>East New Market, Md</u>		24a. REC'D BY REGISTRAR <u>APR 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2133 CENTINALE OF DEATH

40138

5140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>RFD. 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Bradley Jackson</u>		4. DATE OF DEATH Month Day Year <u>April 2 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 18 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RACE TRACK</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JACOB SMITH</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>182-03-7675</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephroclerosis</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 26</u> , 19 <u>60</u> , to <u>April 2</u> , 19 <u>60</u> that I last saw the deceased alive on <u>April 1</u> , 19 <u>60</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Handwritten Signature</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>4/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Handwritten Name</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: Mary Ann Wilson
2. Age: 62 years
3. Sex: Female
4. Date of death: 1921
5. Place of death: Home
6. Cause of death: ...
7. Signature of physician: ...
8. Signature of registrar: ...
9. Date of registration: ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

5141

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05140

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle F. Last Jenkins				4. DATE OF DEATH Month April Day 2 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1887	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Johnson				14. MOTHER'S MAIDEN NAME Minnie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. 220-01-0601		17. INFORMANT Hospital Records Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic gangrene & Diabetic Mellitus 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 1960 to Apr. 2, 1960 , that (I) (we) last saw the deceased alive on Apr. 2, 1960 , and that death occurred at 5:45 PM from the causes and on the date stated above.							
22a. SIGNATURE L. Maldve				22b. DATE SIGNED April 3, 1960			
22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.				22d. ADDRESS Deer's Head State Hosp. Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/7/60			
23c. NAME OF CEMETERY OR CREMATORY Troppe Cemetery				23d. LOCATION (City, town, or county) (State) Troppe Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James A. Daskin				25a. REC'D BY REGISTRAR APR 7 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. House							

1. NAME (Last, First, Middle Initial)		2. GRADE		3. BRANCH	
4. SERVICE NUMBER		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. HOME ADDRESS		8. HOME PHONE		9. HOME CITY	
10. HOME STATE		11. HOME ZIP		12. HOME COUNTRY	
13. EDUCATION		14. MARITAL STATUS		15. NUMBER OF CHILDREN	
16. RELIGION		17. RACE		18. ETHNICITY	
19. OCCUPATION (Before Service)		20. SPECIAL TRAINING		21. ACHIEVEMENTS	
22. REASON FOR LEAVING SERVICE		23. DATE OF LEAVING SERVICE		24. CURRENT ADDRESS	
25. CURRENT PHONE		26. CURRENT CITY		27. CURRENT STATE	
28. CURRENT ZIP		29. CURRENT COUNTRY		30. SIGNATURE	
31. DATE OF SIGNATURE		32. WITNESS SIGNATURE		33. WITNESS DATE	

5142 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Private Sanitarium 505 Hammond St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HOWARD Last JERMAN		4. DATE OF DEATH APRIL 27th 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee-R.D.Grier & Co.		10b. KIND OF BUSINESS OR INDUSTRY Machinist	11. BIRTHPLACE (State or foreign country) Willards, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Ananias Jerman	
14. MOTHER'S MAIDEN NAME Maggie - Unk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. INFORMANT		17. ADDRESS Mr. Edgar A. Jerman (Son) 205 New York Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Hypertensive DUE TO (b) Prostatic Hypertrophy DUE TO (c) Generalized Atherosclerosis & Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs. 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/6 , 19 59 , to MARCH 15, 1960 that I last saw the deceased alive on 12 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MED. CENTER SALISBURY, MD DATE SIGNED April 28, 1960			
ACTUAL SIGNATURE William B Long		M.D. Dr. William B. Long	
PHYSICIAN'S NAME (Type) Dr. William B. Long		Medical Center Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Apr. 29, 1960	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR MAY 2 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Charles L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Location

Residence

Applicant (Print Name and Address)

Deceased (Print Name and Address)

Date of Death (Print Date)

Place of Death (Print Name and Address)

Signature of Deceased (Print Name)

Signature of Applicant (Print Name and Address)

Signature of Physician (Print Name and Address)

Signature of Coroner (Print Name and Address)

Signature of Registrar (Print Name and Address)

Signature of Minister (Print Name and Address)

Signature of Priest (Print Name and Address)

Signature of Rabbi (Print Name and Address)

Signature of Imam (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

Signature of Minister of Religion (Print Name and Address)

5143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David G. Jones, Sr.		4. DATE OF DEATH Month 4 Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/1913
9. AGE (In years lost birthday) yrs. 46		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. Operator		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Jones		14. MOTHER'S MAIDEN NAME Armentia Downing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW#2		16. SOCIAL SECURITY NO. 214-10-9310	
17. INFORMANT Mrs. Dorothy Jones, 614 Lake St., Salisbury, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5877.0 DUE TO Acute Hemorrhagic Pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 14 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-12 , 19 60 , to 4-25 , 19 60 , that I last saw the deceased alive on 4-25 , 19 60 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Earl L. Royer M.D. 4-26-60			
22. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 4/28/60		22c. NAME OF CEMETERY OR CREMATORY Green Acre Memorial Park	
22d. LOCATION (City, town, or county) (State) Salisbury, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md.		24. REC'D BY REGISTRAR DATE MAY 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1913

OBITUARY

Blank certificate form with faint horizontal lines and two punch holes on the right side.

5144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTOVER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General</u>				d. STREET ADDRESS <u>19X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jackson Ketch</u>				4. DATE OF DEATH Month Day Year <u>April 16 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN - ABOUT 77 yrs.</u>	
9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>WEST, VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
INFORMANT Address <u>PRINCESS SOMERSET COUNTY WELFARE BOARD - ANNE, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>60</u> , to <u>4/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>60</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4/16/60</u>			
PHYSICIAN'S NAME (Type) <u>EARL M. BEARDSLEY, M.D.</u>				<u>SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PRIVATE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTOVER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS - CRISFIELD, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

514

10

11

MASTERS & COMPANY, LIMITED, GENERAL MANAGERS
HONG KONG & SHANGHAI FREEPORT, HONG KONG

NAME OF DECEASED: WONG, YU KONG
AGE: 35 YEARS
SEX: MALE
DATE OF DEATH: 1945
PLACE OF DEATH: HONG KONG
CAUSE OF DEATH: ...
SIGNATURE OF MEDICAL OFFICER: ...
SIGNATURE OF REGISTRAR: ...

5145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Eldorado</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>David</u> Last <u>LANK</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min.	11. IF UNDER 24 HRS. Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Lank</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Driscoll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-16-4545</u>	
INFORMANT <u>Mrs. Delema M. Lank, Rhodesdale, Md., R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Aneurysm of Abdominal Aorta</u> <u>451X</u> DUE TO (b) <u>Arteriosclerosis of Aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/9</u> , 19 <u>66</u> , to <u>4/9</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>66</u> , and that death occurred at <u>6:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4/9/66</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 12, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brookview, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '66</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>MARIE</u> Last <u>MC MANEMON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Baby</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25, 1960</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR Months <u>23</u> Days <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>(Unk)</u>		14. MOTHER'S MAIDEN NAME <u>Marie M. McGill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mrs. Marie McManemon (Mother) 621 Truitt St Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Failure to establish Circulation</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>60</u> , to <u>4-26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D. <u>Shy</u>		DATE SIGNED <u>Apr. 28-1960</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 28, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		24. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9-58

2282272XV2

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the patient be examined by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

5147

65146

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 59 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Belle		First Morris		Last April		4. DATE OF DEATH Month 1 Day 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/1879	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cheffins				14. MOTHER'S MAIDEN NAME Arbella Dempsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No data		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Deer's Head Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis, Generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour: a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1960 to April 1, 1960 , that (I) (we) last saw the deceased alive on April 1, 1960 and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/1/60			
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-4-60		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaes		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE APR 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF BIRTH

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CERTIFICATE OF DEATH65147
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u> d. STREET ADDRESS <u>23X-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Curtis</u> First <u>Walter</u> Middle <u>Murray</u> Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1960</u> 9. AGE (In years lost birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <u>William Murray</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>220-52-0477</u> 14. MOTHER'S MAIDEN NAME <u>Julia Campbell</u> 17. INFORMANT <u>Mae Murray</u> Address <u>Whaleyville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Purulent Tracheobronchitis</u> DUE TO (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post Cobalt Rx for Ca of larynx = laryngeal edema</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>15 April</u> , 19 <u>60</u> , to <u>16 April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>16 April</u> , 19 <u>60</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>707 Camden Ave.</u> <u>4-16-60.</u> ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u> M.D. PHYSICIAN'S NAME (Type) <u>Salisbury Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4-18-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Seabysville D.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u> ADDRESS <u>Pocomoke City, Md.</u> 24a. RECEIVED BY REGISTRAR DATE <u>APR 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knepp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

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(M)

(1)

Let's do it

5150

CERTIFICATE OF DEATH

65148
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Perkins General Hospital</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IN DEAN MARIE PARKS</u>				4. DATE OF DEATH Month Day Year <u>April 2 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 2, 1960</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM ALBERT PARKS</u>				14. MOTHER'S MAIDEN NAME <u>BETTY IRENE FUSKEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Mr. W. A. Parks Berlin MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Separation of Placenta</u> 761.5 DUE TO (b) <u>Premature birth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>April 2 1960</u> that I last saw the deceased alive on <u>4-2</u> , 19 <u>60</u> , and that death occurred at <u>7:45 AM</u> , from the causes on and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u>							
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.				DATE SIGNED <u>4/3/60</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis A. Purbaye</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Harris</u>	

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Page 4
The law requires that the death certificate be executed within 24 hours after death.
The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5177

CERTIFICATE OF DEATH

Reg. Dist. No.

5149

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Old Delmar Rd)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle LEE Last PARSONS		4. DATE OF DEATH Month APRIL Day 23rd Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 9 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer -		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pittsville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George Riley Parsons	
14. MOTHER'S MAIDEN NAME Cordelia Elliott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk	
16. SOCIAL SECURITY NO. Informant		17. ADDRESS Mrs. Ada (Mae) Parsons (Wife) R.D.# 3 Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 4 days 6 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from 1954 to 4-23 , 19 60 , that I last saw the deceased alive on 4-15 , 19 60 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Dr. L.V. Sohler M.D.		DATE SIGNED April 25, 1960	
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		Delmar, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 26, 1960	22c. NAME OF CEMETERY OR CREMATORY Charity Church Cem. - Near Salisbury, Maryland	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR APR 27 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00119

CENTRAL OFFICE

311

Wisconsin

State of Wisconsin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

65150

Item 1 Film G262 3/4/60 iwk

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville, Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION his home - Whiton Rd.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X POWELLVILLE d. STREET ADDRESS 1 WHITON RD.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last PERDUE				4. DATE OF DEATH Month APRIL Day 25 Year 1960					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 15, 1917		9. AGE (In years last birthday) 43 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) POWELLVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES S. PERDUE				14. MOTHER'S MAIDEN NAME ANNIE MAY LEWIS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT MR. CHARLES GULBOURNE POWELLVILLE MD Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 10 yrs								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MULTIPLE DEFORMITIES DUE TO POLIOMYELITIS								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to April 25, 1960 , that (I) (we) last saw the deceased alive on April 25, 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Robert C. La Mar				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert C. La Mar, M. D.				22d. ADDRESS 104 Bay St., Snow Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/60		23c. NAME OF CEMETERY OR CREMATORY POWELLVILLE CEM		23d. LOCATION (City, town, or county) POWELLVILLE MD. (State) MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kenna				ADDRESS Powellville Md		25a. REC'D BY REGISTRAR APR 29 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (See #20e)		d. STREET ADDRESS Lillian St	

3. NAME OF DECEASED (Type or print) First NORRIS Middle WOODLAND Last PHILLIPS		4. DATE OF DEATH Month April Day 9th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1915
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 8 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Marvel Package Co. (Machinist)	10b. KIND OF BUSINESS OR INDUSTRY Siloam, Maryland	11. BIRTHPLACE (State or foreign country) U S A	12. CITIZEN OF WHAT COUNTRY? U S A
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13. FATHER'S NAME Kensley F. Phillips	14. MOTHER'S MAIDEN NAME Mattie E. Flemming
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk	16. SOCIAL SECURITY NO. Unk	17. INFORMANT Mrs. Evelyn L. Phillips (Wife) Hebron, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Instant
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Small Boat overturned while fishing.		
20c. TIME OF INJURY Month, Day, Year 5 a.m. 4-9 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marley Lake Creek	20f. (City or town) (County) (State) Wicomico Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Earl L. Royer	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED April 18/1960
EXAMINER'S NAME (Type) Dr. Earl L. Royer	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 19, 1960	22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Hebron, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR APR 19 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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5151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				1d. STREET ADDRESS <u>422 Priscella St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>BELLE</u> Last <u>Pollitt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1899</u>		9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee at Deer's</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Head State Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James F. Marvel</u>				14. MOTHER'S MAIDEN NAME <u>Clara Belle Beach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Mr. Alexander Pollitt (Husband) 422 Priscella St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Renal insufficiency with uremic syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. } DUE TO <u>nephrosclerosis</u> (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>34 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/7</u> , 19 <u>60</u> , to <u>4/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>60</u> , and that death occurred at <u>5:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u>		M.D.		ADDRESS (Street, city or town, state) <u>Pinebluff Rd. Salisbury, Md.</u>		DATE SIGNED <u>4/10/60</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

446X

TO HOLLOWAY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5152

CERTIFICATE OF DEATH

Reg. Dist. No.

65153

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>MARIE</u> Last <u>Pryor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1923</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper (J.H. Dulany & Son)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lewis C. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Mamie V. Pusey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mr. Alton D. Pryor (Husband)</u> Address <u>R.D.# 1 Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>274X</u> IMMEDIATE CAUSE (a) <u>Auricular Tachycardia with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Circulatory Collapse</u> DUE TO (c) <u>Acute Adrenal Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>60</u> , to <u>4/13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>60</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pine Bluff Rd. Salisbury, Md.</u> DATE SIGNED <u>4/13/60</u>			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D.# Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>APR 18 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

65158

CERTIFICATE OF DEATH

1-1-1951

1-1-1951

1-1-1951

1-1-1951

1-1-1951

U.S.A.

1-1-1951

1-1-1951

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Reg. Dist. No.

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VS AIS (4)
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5180

CERTIFICATE OF DEATH

65155
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Parsonsburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg (Rural)	
d. STREET ADDRESS R.D.#		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ESCHOL Last SCOTT		4. DATE OF DEATH Month APRIL Day 14th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1885
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) R.D.# Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Arthur Scott		14. MOTHER'S MAIDEN NAME Ida K. Bodley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Florence E. Scott (Wife) R.D.# Parsonsburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomp 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic C-V Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 3/4 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to April 14, 1960 , that I last saw the deceased alive on April 12, 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland DATE SIGNED April 15/1960 ACTUAL SIGNATURE William D. Gray M.D. PHYSICIAN'S NAME (Type) Dr. William D. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 17, 1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 18 '60	24b. REGISTRAR'S SIGNATURE William E. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

1

TO DISTRIBUTE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 65156											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 518 Tangier St.					d. STREET ADDRESS 518 Tangier St.						
3. NAME OF DECEASED (Type or print) First Charles Middle Selby Last Selby					4. DATE OF DEATH Month 4 Day 17 Year 60						
5. SEX M		6. COLOR OR RACE A A		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-1918		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 4 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handyman			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Mardela, Md.			12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Henry Selby					14. MOTHER'S MAIDEN NAME Georgianna Deal						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Salisbury, Md. Mrs. Mary Gale 518 Tangier St.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute alcoholism (c) Acute alcoholism DUE TO cause lost. INTERVAL BETWEEN ONSET AND DEATH Hours Hours											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Earl L. Royer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Earl L. Royer, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-21-60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-60		22c. NAME OF CEMETERY OR CREMATORY Green Acre			22d. LOCATION (City, town, or county) (State) Salisbury, Md. Wicomico				
23. FUNERAL DIRECTOR'S SIGNATURE Thomson B. Jolly, Salisbury, Md.					24a. REC'D BY REGISTRAR APR 25 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Frank				

5155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>9 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>				d. STREET ADDRESS <u>Princess Anne 18X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Charles Sheller</u> First Middle Last				4. DATE OF DEATH <u>APRIL 23, 1960</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Norwood, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Sheller</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. John Sheller, Princess Anne Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Unknown</u> (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Plus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 22, 1960</u> , to <u>April 23, 1960</u> , that I last saw the deceased alive on <u>April 22, 1960</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>4/24/60</u>			
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leven B. Nelson, Princess Anne, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

Dec 4 1903

Princess Anne

Charles

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5156

CERTIFICATE OF DEATH

65158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>19X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Oriole</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Fonsi</u> Middle <u>A</u> Last <u>Shelton</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1886</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Oriole, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Laird</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		INFORMANT Address <u>Mrs. Walter Mc.Dormon, Monie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 4-20-11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22-1960</u> to <u>4-24-1960</u> that I last saw the deceased alive on <u>April 24, 1960</u> , and that death occurred at <u>12:58</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schum</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4/24/60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oriole, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leven R. Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	
				24c. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>			

5157

CERTIFICATE OF DEATH

65159

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 313 E. Vine St	
3. NAME OF DECEASED (Type or print) First MAGGIE Middle M. Last SHOCKLEY		4. DATE OF DEATH Month APRIL Day 19th Year 1960	
5. SEX Fe-Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1876
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Month 11 Day 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Riverton, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME (Unk)	
14. MOTHER'S MAIDEN NAME (Unk)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. INFORMANT		17. ADDRESS Mrs. Annie Linnette (Friend) 313 E. Vine St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/15/60 19, to 4/19/60 19, that I last saw the deceased alive on 4/19/60 19, and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Andrew C. Mitchell ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED Apr. 19, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1960	22c. NAME OF CEMETERY OR CREMATORY Riverton Cemetery-Near Sharptown
22d. LOCATION (City, town, or county) (State) (Riverton) Md.		23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
24a. REC'D BY REGISTRAR DATE APR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove棺罩 papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1150

CERTIFICATE OF DEATH

1151

Blank certificate form with horizontal lines for text entry.

5158

CERTIFICATE OF DEATH

65160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 632 Liberty St		e. STREET ADDRESS 516 Truitt St	
3. NAME OF DECEASED (Type or print) First MINNIE Middle BLANCHE Last SMITH		4. DATE OF DEATH Month APRIL Day 25th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1893
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR 2 Months 13 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lewis M. Taylor		14. MOTHER'S MAIDEN NAME Elizabeth Wingate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mr. William W. Smith (Husband) 516 Truitt St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic CA of lung DUE TO (b) CA of left breast DUE TO (c) CA of left breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-22 , 19 58 , to 4-25 , 19 60 that I last saw the deceased alive on 4-25 , 19 60 , and that death occurred at 4:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave. Salisbury, Maryland DATE SIGNED April 25 / 1960			
ACTUAL SIGNATURE Earl L. Royer M.D.			
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		407 Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 27, 1960	22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND ADDRESS		24a. REC'D BY REGISTRAR APR 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

WILLIAM J. CUMMINGS

1

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of deceased	2. Sex	3. Age	4. Date of death	5. Place of death
6. Cause of death	7. Signature of physician	8. Signature of registrar	9. Date of registration	10. Place of registration
11. Remarks				

5159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R D #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RACHEL</u> Middle <u>MAY</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1906</u>		9. AGE (In years lost birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Wesley Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Name <u>Rose Allen Smith - Delmar Md</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Hypertensive cardiovascular disease</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-31</u> , 19 <u>60</u> , to <u>4-11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4-11</u> , 19 <u>60</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-11-60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Art Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co - Salisbury</u>				24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13150

STATE OF TEXAS
COUNTY OF DALLAS

268X

[Faint, mostly illegible text, likely a legal document or affidavit, possibly containing names and dates.]

5160

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury/ Berlin, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old age rest home Fitzwater St.		d. STREET ADDRESS Fitzwater Street	
3. NAME OF DECEASED (Type or print) First Sadie Middle Smith Last		4. DATE OF DEATH Month April Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1901
9. AGE (In years last birthday) 5-9 yrs.		IF UNDER 1 YEAR Months 5 Days 9 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Selby	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I	
16. SOCIAL SECURITY NO.		INFORMANT Annle Purnell Branch St. Berlin Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO (b) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from April 28, 1960 to April 30, 1960 that I last saw the deceased alive on April 28, 1960 and that death occurred at 3:00 M. from the causes and on the date stated above.	
ACTUAL SIGNATURE G. Herbert Sembley M.D.		ADDRESS (Street, city or town, state) Salisbury Md	
PHYSICIAN'S NAME (Type) G. Herbert Sembley		DATE SIGNED 5/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/1960	
22c. NAME OF CEMETERY OR CREMATORY Germantown		22d. LOCATION (City, town, or county) (State) Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE Christina Stewart ADDRESS Salis. Md.		24a. REC'D BY REGISTRAR MAY 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF THE ATTORNEY GENERAL

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5161 CERTIFICATE OF DEATH 65163

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke 2342.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 107 Oak Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Burton Last Smith				4. DATE OF DEATH Month April Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/1885	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill work				10b. KIND OF BUSINESS OR INDUSTRY Mill work		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Martha Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-14-4381		17. INFORMANT Deer's Head Hospital Address Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (this hospital) attended the deceased from March 15 , 19 60 , to April 14 , 19 60 , that (I) (we) lost saw the deceased alive on April 14 , 19 60 , and that death occurred at 2:40 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve				22b. DATE SIGNED 2:40 A.M.		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.	
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-60		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Watson				25a. REC'D BY REGISTRAR APR 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	
ADDRESS Pocomoke City, Md.							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5169

CERTIFICATE OF DEATH

Reg. Dist. No. **5164**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Maryland Avenue				d. STREET ADDRESS 6 Maryland Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Smithers				4. DATE OF DEATH Month April Day 23 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1877	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 12 Hours 12 Min.		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad			
13. FATHER'S NAME William H. Smithers				14. MOTHER'S MAIDEN NAME Josephine Saxon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 716-03-1690			
17. INFORMANT Lillie May Smithers, Delmar, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca. of rt. submaxillary Lymph node - large. DUE TO (b) Hemorrhage from ca DUE TO (c) Arteriosclerosis, generalized. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to April 1960 , that I last saw the deceased alive on 4-23-60 , 1960, and that death occurred at Delmar , Md, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar DATE SIGNED 4-23-60 ACTUAL SIGNATURE L.V. Sohler M.D. PHYSICIAN'S NAME (Type) L.V. Sohler M.D. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-26-60			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive				22d. LOCATION (City, town, or county) (State) Delmar, Del.			
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Manel Co - Delmar, Del.				24a. REC'D BY REGISTRAR APR 26 '60			
24b. REGISTRAR'S SIGNATURE Charles E. Harris							

TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
65165

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PEN GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>WEST ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST STEPHENSON</u>				4. DATE OF DEATH Month Day Year <u>APRIL 19 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 24, 1889</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (Wic.Co)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE STEPHENSON</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>213-244835</u>		17. INFORMANT Address <u>MR. PAUL A. STEPHENSON BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema & Anasarca</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Acute Coronary Thrombosis</u> DUE TO (c) <u>Coronary Thrombosis & C.V. R. Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 1955</u> to <u>Apr 19 1960</u> , that (I) (we) last saw the deceased alive on <u>Apr 19 1960</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herman A. Robbins</u> M.D.				22b. ADDRESS <u>Berlin, Md</u>		22c. PHYSICIAN'S NAME (Type) <u>HERMAN A. Robbins M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE</u>		23d. LOCATION (City, town, or county) (State) <u>WILLARDS MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Jean TINDLEY</u>				4. DATE OF DEATH Month Day Year <u>APRIL 19, 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9 - 1919</u>	9. AGE (In years lost birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bultryp Pressing</u>		11. BIRTHPLACE (State or foreign country) <u>Seelyville, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tindley</u>				14. MOTHER'S MAIDEN NAME <u>Leah Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>222-09-7531</u>		INFORMANT <u>Vera Moore</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral Arteriosclerosis And</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>1+ years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>April 19, 1960</u> , to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 19, 1960</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u>		DATE SIGNED <u>4/19/60</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 23, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksville Del.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5166

CERTIFICATE OF DEATH

05167
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY REIGART TOADVIN</u>		4. DATE OF DEATH Month Day Year <u>APRIL 3 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL W. REIGART</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HODGSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JOHN R. NIESLEY</u> Address <u>015 ROSLYN RD MINEOLA, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 CEREAL THROMBOSIS</u> DUE TO <u>CEREBRO VASCULAR ACCIDENT.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>ATHERO SCLEROTIC CARDIO VASCULAR DISEASE</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE CARDIAC FAILURE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 54 to 45 4/3/ 1960</u> , that I last saw the deceased alive on <u>4/3/ 19 60</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SALISBURY, MD</u> DATE SIGNED <u>4-3-1960</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		FUNDING SIGNATURE <u>O. J. BURTON</u> 211 MARYLAND AVE SALISBURY, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u> ADDRESS <u>SALISBURY, MD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

MASSACHUSETTS

1. Name of Deceased: *Samuel W. Reinhardt*
2. Sex: *Male*
3. Age: *68*
4. Date of Death: *June 1, 1910*
5. Place of Death: *Home*
6. Cause of Death: *Heart Disease*
7. Signature of Physician: *John R. Moley*
8. Signature of Registrar: *John R. Moley*
9. Date of Registration: *June 1, 1910*
10. Place of Registration: *Massachusetts*

5165
CERTIFICATE OF DEATH65168
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b all her life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 Rose Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Wailes		4. DATE OF DEATH Month 4 Day 27 Year 19 60	
5. SEX Female	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Handy Pullitt		14. MOTHER'S MAIDEN NAME Josephine Fooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Informant Address Mrs. Viola Woods, 509 Rose St., Salisbury, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334x IMMEDIATE CAUSE (a) Cerebrovascular DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Indefinite (c) Indefinite PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Indefinite 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 20 MAR 1960 to 27 Apr 60 that I last saw the deceased alive on 27 Apr 1960 and that death occurred at 7am from the causes and on the date stated above. ADDRESS (Street, city or town, state) 652 W main DATE SIGNED 29 Apr 60 ACTUAL SIGNATURE E. A. Purnell M.D. 652 W main PHYSICIAN'S NAME (Type) E. A. Purnell, M. D. 652 West Main St., Salisbury, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/1/60	22c. NAME OF CEMETERY OR CREMATORY Green Acre Mem Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		24. REC'D BY REGISTRAR DATE MAY 3 '60	
24b. REGISTRAR'S SIGNATURE Ciribus L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1010

UNITED STATES OF AMERICA

1010

1

CERTIFICATE OF DEATH

15169
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Dist. before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - POCOMOKE CITY 23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Washington</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>PETER E. WARREN</u>	
14. MOTHER'S MAIDEN NAME <u>ARKANSAS JARMON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-36-0853</u>		17. INFORMANT <u>MRS MARY H. WARREN, POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>518X</u> IMMEDIATE CAUSE (a) <u>Overwhelming infection</u> DUE TO (b) <u>Purulent pericarditis</u> DUE TO (c) <u>Empyema + mediastinitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 weeks?</u> <u>5 weeks?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thyroidectomy and RU+RM lobectomy 2-27-60</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1960</u> to <u>9 April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9 April</u> , 19 <u>60</u> , and that death occurred at <u>4:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>707 Camden Ave</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-12-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap on papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5181

CERTIFICATE OF DEATH

Reg. 1910 No. 5120

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First ELMER Middle CHARLES Last WILKINS				4. DATE OF DEATH Month April Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultryman		10b. KIND OF BUSINESS OR INDUSTRY Own place		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-34-3548		17. INFORMANT Mrs. Maude P. Wilkins, Willards, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thromboses 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis-atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12, 1960 , to April 13, 1960 , that I last saw the deceased alive on April 13, 1960 , and that death occurred at 2:21 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Lewis				ADDRESS (Street, city or town, state) Willards, Maryland DATE SIGNED 12-14-60			
PHYSICIAN'S NAME (Type) Frank Lewis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/60		22c. NAME OF CEMETERY OR CREMATORY New Hope		22d. LOCATION (City, town, or county) (State) Willards, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville Del.				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Charles L. Krouse	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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CERTIFICATE OF DEATH

420.8

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

5167 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MAE WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>APRIL 19 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>July 31, 1892</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>William Timmons</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kelley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Maggie W. Ruark (Daughter) Pacific Ave. Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>degenerative heart disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk. 5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/19/60</u> to <u>4/19/60</u> , that I last saw the deceased alive on <u>4/19/60</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.		ADDRESS (Street, city or town, state) <u>Maryland Ave. Salisbury, Md.</u> DATE SIGNED <u>4/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earl M. Beardsley</u>		<u>Maryland Ave. Salisbury, Md.</u> <u>4/19/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Powellville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>APR 21 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05172

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Willards Rural #2</i>		c. LENGTH OF STAY IN 1b <i>2 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Beulah</i> Middle <i>Wise</i> Last <i>Wise</i>		4. DATE OF DEATH Month <i>April</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 13 - 1907</i>
9. AGE (In years last birthday) <i>53 1/2</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Newcomb</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Andrew Wise</i> Address <i>Willards, md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocarditis (chronic)</i> <i>Rural #2</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>Hypertension (arteriosclerosis)</i> DUE TO (c) <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>January 1960</i> to <i>April 4</i> 1960; that (I) (we) last saw the deceased alive on <i>April 3</i> 1960, and that death occurred at <i>59</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank Lewis</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-5-1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Frank Lewis</i>		22d. ADDRESS <i>Willards Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 6/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parble Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Parble Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Alley B. Summis</i> ADDRESS <i>Snow Hill, md</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> 25b. REGISTRAR'S SIGNATURE	
DATE <i>APR 7 '60</i>			

00178

CERTIFICATE OF DEATH

5152

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical report.]

05173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R. R. 2.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>HENRY</u> Last <u>Zott</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 3th. 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>GEORGE LEONARD ZOTT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH THRESIA KINZLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-24-4916</u>	
17. INFORMANT <u>MRS. LULU E. ZOTT, GREENWOOD, DEL.</u>		Address <u>R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Acute</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suprapubic prostatectomy performed April 7, 1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31</u> , 19 <u>60</u> , to <u>April 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>60</u> , and that death occurred at <u>6:40</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond M. Yow</u>		ADDRESS (Street, city or town, state) <u>207 Camden Ave Salisbury, Md.</u>	
DATE SIGNED <u>4-10-60</u>			
PHYSICIAN'S NAME (Type) <u>(Mrs.) R. H. Boyer, Harrington, Del.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APR. 14, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BRIDGEVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BRIDGEVILLE, DEL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs.) R. H. Boyer, Harrington, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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